BEFORE THE DIVISION OF INSURANCE

STATE OF COLORADO

FINAL AGENCY ORDER O-10-003

IN THE MATTER OF THE MARKET CONDUCT EXAMINATION OF UNITED HEALTHCARE OF COLORADO, INC.

Respondent

THIS MATTER comes before the Colorado Commissioner of Insurance (the "Commissioner") as a result of a market conduct examination conducted by the Colorado Division of Insurance (the "Division") of United HealthCare of Colorado, Inc. (the "Respondent"), pursuant to §§ 10-1-201 to 207, and 10-16-416, C.R.S. The Commissioner has considered and reviewed the market conduct examination report dated April 30, 2009 (the "Report"), relevant examiners' work papers, all written submissions and rebuttals, and the recommendations of staff. The Commissioner finds and orders as follows:

FINDINGS OF FACT

1. At all relevant times, the Respondent was licensed by the Division as a health maintenance organization.

2. In accordance with §§ 10-1-201 to 207, and 10-16-416, C.R.S., on April 30, 2009, the Division completed a market conduct examination of the Respondent. The period of examination was January 1, 2007 to December 31, 2007.

3. In scheduling the market conduct examination and in determining its nature and scope, the Commissioner considered such matters as complaint analyses, underwriting and claims practices, pricing, product solicitation, policy form compliance, market share analyses, and other criteria as set forth in the most recent available edition of the Market Regulation Handbook adopted by the National Association of Insurance Commissioners, as required by § 10-1-203(1), C.R.S.

4. In conducting the examination, the examiners observed those guidelines and procedures set forth in the most recent available edition of the Market Regulation Handbook adopted by the National Association of Insurance Commissioners and the Colorado insurance examiners' handbook. The Commissioner also employed other guidelines and procedures that she deemed appropriate, pursuant to § 10-1-204(1), C.R.S.

5. The market conduct examiners prepared a Report. The Report is comprised of only the facts appearing upon the books, records, or other documents of the Respondent, its agents or other persons examined concerning Respondent's affairs. The Report contains the conclusions and recommendations that the examiners find reasonably warranted based upon the facts.

6. Respondent delivered to the Division written submissions and rebuttals to the Report.

7. The Commissioner has fully considered and reviewed the Report, all of Respondent's submissions and rebuttals, and all relevant portions of the examiners' work papers.

CONCLUSIONS OF LAW AND ORDER

8. Unless expressly modified in this Final Agency Order ("Order"), the Commissioner adopts the facts, conclusions and recommendations contained in the Report. A copy of the Report is attached to the Order and is incorporated by reference.

9. Issue H1 concerns the following violation: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan. The Respondent shall provide evidence to the Division that it has implemented procedures to ensure that each member of a terminating small group, for reasons other than replacement of coverage or fraud and abuse in procuring and utilizing coverage, is offered a choice of the Basic or Standard Health Benefit Plan in compliance with Colorado insurance law. *(This was prior issue H4 in the findings of the 2002 final exam report.)* In the Market Conduct examination for the period January 1, 2002 through December 31, 2002, the Company was cited for failure to offer Basic and Standard Plan conversion coverage to terminating small employer groups. The violation resulted in Recommendation #24; that the Company revise its procedures to ensure that a choice of the Basic or Standard Health Benefit Plans is offered to each member of the group whose policy is terminating, as required by Colorado insurance law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of § 10-1-205, C.R.S.

10. Issue H2 concerns the following violation: Failure to reflect the definition of a "significant break in coverage" in certificates of creditable coverage. The Respondent shall provide evidence to the Division that it has implemented procedures to ensure that all Certificates of Creditable Coverage reflect the full definition of a "significant break in coverage" in compliance with

Colorado insurance law.

11. Issue J1 concerns the following violation: Failure, in some instances, to process claims correctly. The Respondent shall provide evidence to the Division that it has reviewed and modified its claims processing quality controls to ensure that all claims are investigated properly to determine that proper allocation of benefits as required by Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

12. Issue J2 concerns the following violation: Failure, in some cases, to pay late payment interest and/or penalties. The Respondent shall provide evidence to the division that it has implemented procedures to ensure that late payment penalties are paid in all applicable instances as required by Colorado insurance law. Additionally, a self audit shall be performed for the period beginning January 1, 2007 through the date of this Order to ensure that all interest and penalties due are properly disbursed on all late claims.

13. Issue J3 concerns the following violation: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law. The Respondent shall provide evidence to the Division that it has implemented procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

14. Issue J4 concerns the following violation: Failure to correctly process claims for out-of-network services/treatment associated with services/treatment rendered at an in-network facility. The Respondent shall provide evidence to the Division that is has revised its claim payment procedures to ensure that all out-of-network professional claims are processed correctly when the claims are received prior to, but in connection with, an in-network facility claim in compliance with Colorado insurance law. Additionally, a self audit shall be performed for the period beginning January 1, 2007 through the date of this Order to ensure that all out-of-network claims related to an in-network facility claim were paid at the proper benefit level, and that interest and penalties are properly disbursed where appropriate.

15. Issue K1 concerns the following violation: Failure, in some instances, to have a physician evaluate first level reviews, and to take into consideration the treating provider's comments in conducting a first level review that resulted in a denial, and to include all required information in denial notification letters for first level reviews. The Respondent shall provide evidence to the Division that it has implemented procedures to ensure that all first level reviews are evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer, that the treating provider's comments are taken into consideration on all first level reviews, and that all First Level Appeal

determination letters contain all the information required by Colorado insurance law. (*This was a partial repeat of prior issue K4 in the findings of the 2002 final examination report.)* In the Market Conduct examination for the period January 1, 2002 through December 31, 2002, the Company was cited for failure to include all required information in denial notification letters for First Level Appeals. The violation resulted in Recommendation #32; that the Company revise its procedures to ensure that all First Level Appeal determination letters contain all the information required by Colorado insurance law. Failure to comply with this previous recommendation and order of the commissioner may constitute a violation of §10-1-205, C.R.S. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

16. Issue K2 concerns the following violation: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician. The Respondent shall provide evidence to the Division that it has implemented procedures to ensure that all written denials of requests for covered benefits on the grounds that such benefits are not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado as required by Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation. Additionally, the company shall ensure that all cases signed by a "Resolving Analyst" from January 1, 2007 through the date of this Order are reviewed by a licensed physician, and that any corrections necessary by the physician review are made.

17. Issue K3 concerns the following violation: Failure, in some instances, to provide notification of determination within the required time frames. The Respondent shall provide evidence to the Division that it has implemented procedures to ensure that all utilization review determinations are made within the time periods required by Colorado insurance law. *(This was prior issue K1 in the findings of the 2002 final examination report.)* In the Market Conduct examination for the period January 1, 2002 through December 31, 2002, the Company was cited for failure to make utilization review determinations and provide required notifications within the time frames allowed under Colorado insurance law. The violation resulted in Recommendation #29; that the Company revise its procedures to ensure that the time frames for determination and notification of utilization review decisions meet the requirements of Colorado insurance law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of §10-1-205 C.R.S.

18. Pursuant to § 10-1-205(3)(d), C.R.S, the Respondent shall pay a civil penalty to the Division in the amount of Two Hundred Eleven Thousand and

no/100 dollars ($211,000.00) for the cited violations of Colorado law. This fine was calculated in accordance with Division guidelines for assessing penalties and fines, including Division Bulletin No. B-1.3, originally issued on January 1, 1998, re-issued May 8, 2007. Said penalty shall be assessed a 15% surcharge up to $200,000, or $30,000.00, pursuant to 24-34-108, C.R.S. for a total balance due of $241,000.00 which will be due to the Division within 30 days of the signing of this Final Agency Order. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program.

19. Pursuant to § 10-1-205(4)(a), C.R.S., within sixty (60) days of the date of this Order, the Respondent shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related Order.

20. Unless otherwise specified in this Order, all requirements with this Order shall be completed within thirty (30) days of the date of this Order. Respondent shall submit written evidence of compliance with all requirements to the Division within the thirty (30) day time frame, except where Respondent has already complied, as specifically noted in the Order. Forms violations may be corrected by revising the appropriate noncompliant area(s) of the forms, or by issuing an addendum to correct the noncompliant areas if the Company is unable to correct the actual form within the required time period. Copies of any rate and form filings shall be provided to the rate and forms section with evidence of the filings sent to the market conduct section. All self audits, if any, shall be performed in accordance with Division's document, 'Guidelines for Self Audits Performed by Companies', Unless otherwise specified in this Order, all self audit reports must be received within ninety (90) days of the Order, including a summary of the findings and all monetary payments to covered persons.

21. This Order shall not prevent the Division from commencing future agency action relating to conduct of the Respondent not specifically addressed in the Report, not resolved according to the terms and conditions in this Order, or occurring before or after the examination period. Failure by the Respondent to comply with the terms of this Order may result in additional actions, penalties and sanctions, as provided for by law.

22. Copies of the examination report, and this final Order will be made available to the public no earlier than thirty (30) days after the date of this Order, subject to the requirements of § 10-1-205, C.R.S.

WHEREFORE: It is hereby ordered that the findings and conclusions contained in the Report dated April 30, 2009, are hereby adopted and filed and made an

official record of this office, and the above Order is hereby approved this 28th day of August, 2009.

Marcy Morrison
Commissioner of Insurance

CERTIFICATE OF MAILING

I hereby certify that on the 28th day of August, 2009, I caused to be deposited the **FINAL AGENCY ORDER NO. O-10-003 IN THE MATTER OF THE MARKET CONDUCT EXAMINATION OF UNITED HEALTHCARE OF COLORADO, INC.,** in the United States Mail via certified mailing with postage affixed and addressed to:

Ms. Elizabeth Soberg
United Healthcare of Colorado, Inc.
6465 S. Greenwood Plaza Blvd, #3000
Centennial, CO 80111

Eleanor Patterson
Market Regulation Administrator
Division of Insurance